

Bureau of Insurance

Cumulative Impact of Mandates in Maine

Report for the Year 2011

This report provides data for medical insurance coverage mandates as required by 24-A M.R.S.A. §2752 and compiled by the Bureau of Insurance. While some data was provided through annual mandate reports by insurers, other figures were estimated as a part of the proposed mandates study. The following provides a brief description of each mandate and the estimated claim cost as a percentage of premium. A summary chart is provided at the end of this report.

- **Mental Health** (Enacted 1983)

The mental health mandate requires that benefits be provided for mental health services, and it applies to all group plans, with the exception of non-HMO employee group plans covering 20 or fewer employees. Mental health parity for listed conditions became effective July 1, 1996, and was expanded effective October 1, 2003. The percentage of mental health claims paid has been tracked since 1984 and has historically been between 3% and 4% of total group health claims and was reported as 3.42% in 2011. Mental health claims stayed below 3.5%, despite the fact that an expansion of the list of conditions for which parity is required was fully implemented in 2005. We estimate a continuation of 2011 levels going forward. For HMO plans covering employers with 20 or fewer employees, this report uses half the value for larger groups to reflect the fact that parity does not apply. Although it is likely that some of these costs would be covered even in the absence of a mandate, there is no basis for estimating how much. We have included the entire amount for mandated plans, thereby overstating the impact of the mandate to some extent; however, this overstatement is at least partially offset by the fact that the data is an aggregate of all groups, while groups of 20 or fewer are exempt from the parity requirement in the case of HMO coverage and from the entire mandate in the case of non-HMO coverage.

- **Substance Abuse** (Enacted 1983)

This mandate requires the provision of benefits for alcoholism and drug dependency and applies only to groups of more than 20. Effective October 1, 2003, substance abuse was added to the list of mental health conditions for which parity is required. The percentage of claims paid has been tracked since 1984. For 2011, substance abuse claims paid were 0.66% of the total group health claims. Despite implementation of the parity requirement, there was a long-term decrease in the percentage, likely due to utilization review, which sharply reduced the incidence of inpatient care. Inpatient claims decreased from about 93% of the total in 1985 to 37% in 2011. The percentage of claims is further broken out by HMO and other health plans but the relationship is inconsistent from year to year. We estimate substance abuse benefits will remain at the current levels going forward. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire

amount, thereby overstating the impact of the mandate to some extent; however, this overstatement is offset by the fact that the data is an aggregate of all groups, while the mandate applies only to groups larger than 20.

- ♦ ***Chiropractic*** (Enacted 1986)

This mandate generally requires coverage for the services of chiropractors to the extent that the same services would be covered if performed by a physician. Using annual experience reports from the carriers, the percentage of claims paid has been tracked since 1986 and, in 2011, was 0.89% of total health claims. The level has typically been lower for individual than for group. The level does vary between HMOs and other plans. For 2011, the percentages for group plans were 1.35% for HMO plans, 0.67% for other plans. We estimate the current levels going forward. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ♦ ***Screening Mammography*** (Enacted 1990)

This mandate requires that benefits be provided for screening mammography. The U.S. Preventive Services Task force has recommended that screening mammograms begin at a later age and be done less frequently. While it is possible this will lead to reduced utilization, the American Cancer Society, The American College of Obstetricians and Gynecologists, and many oncologists have not accepted these recommendations. We, therefore, estimate the current level of 0.67% in all categories going forward. Although it is likely that some of these costs would be covered even in the absence of a mandate, we have no basis for estimating how much. We have included the entire amount, thereby overstating the impact of the mandate to some extent.

- ♦ ***Dentists*** (Enacted 1975)

This mandate requires coverage for dentists' services to the extent that the same services would be covered if performed by a physician. It does not apply to HMOs. A 1992 study done by Milliman and Robertson for the Mandated Benefits Advisory Commission estimated that these claims represent 0.5% of total health claims and that the actual impact on premiums is "slight." It is unlikely that this coverage would be excluded in the absence of a mandate. We include 0.1% as an estimate.

- ♦ ***Breast Reconstruction*** (Enacted 1998)

This mandate requires coverage for reconstruction of both breasts to product a symmetrical appearance after a mastectomy. At the time this mandate was being considered in 1995, one carrier estimated the cost at \$0.20 per month per individual. We do not have a more recent estimate. We include 0.02% in our estimate of the maximum cumulative impact of mandates.

- ♦ ***Errors of Metabolism*** (Enacted 1995)

This mandate requires coverage for metabolic formula and up to \$3,000 per year for prescribed

modified low-protein food products. At the time this mandate was being considered in 1995, Blue Cross estimated the cost at \$0.10 per month per individual. We do not have a more recent estimate. We include 0.01% in our estimate.

- ♦ ***Diabetic Supplies*** (Enacted 1996)

This mandate requires that benefits be provided for medically necessary diabetic supplies and equipment. Based on data collected in 2006, most carriers reported that there would be no cost or an insignificant cost because they already provide this coverage. Based on our report we estimate 0.2%.

- ♦ ***Minimum Maternity Stay*** (Enacted 1996)

This mandate requires that if a policy provides maternity benefits, the maternity (length of stay) and newborn care benefits must be provided in accordance with “Guidelines for Prenatal Care.” Based on carrier responses indicating that they did not limit maternity stays below those recommended, we estimate no impact.

- ♦ ***Pap Smear Tests*** (Enacted 1996)

This mandate requires that benefits be provided for screening Pap smear tests. HMOs would typically cover these costs and, for non-HMO plans, the relatively small cost of this test would not in itself satisfy the deductible, so there would be no cost unless other services were also received. We estimate a negligible impact of 0.01%.

- ♦ ***Annual GYN Exam Without Referral*** (Enacted 1996)

This mandate only affects HMO plans and similar plans, and it requires the provision of benefits for annual gynecological exams without prior approval from a primary care physician. To the extent the Primary Care Physician (PCP) would, in absence of this law, have performed the exam personally rather than referring to an OB/GYN, the cost may be somewhat higher; therefore, we include 0.1%.

- ♦ ***Breast Cancer Length of Stay*** (Enacted 1997)

This mandate requires that benefits for breast cancer treatment be provided for a medically appropriate period of time as determined by the physician in consultation with the patient. Our report estimated a cost of 0.07% of premium.

- ♦ ***Off-label Use Prescription Drugs*** (Enacted 1998)

This mandate requires coverage of off-label prescription drugs in the treatment of cancer, HIV, and AIDS. Our 1998 report stated a "high-end cost estimate" of about \$1 per member per month (0.6% of premium) if it is assumed there is currently no coverage for off-label drugs. Because the HMOs claimed to already cover off-label drugs, in which case there would be no additional cost; and, providers testified that claims have been denied on this basis, we include half this amount, or 0.3%.

- ♦ ***Prostate Cancer*** (Enacted 1998)

This mandate requires prostate cancer screenings if recommended by a physician, at least once a year for men 50 years of age or older until a man reaches the age of 72. No increase in premiums should be expected for the HMOs that provide the screening benefits currently as part of their routine physical exam benefits. Our report estimated additional claims cost for non-HMO plans would approximate \$0.10 per member per month. With the inclusion of administrative expenses, we would expect a total cost of approximately \$0.11 per member per month, or approximately 0.07% of total premiums.

- ♦ ***Nurse Practitioners and Certified Nurse Midwives*** (Enacted 1999)

This law mandates coverage for nurse practitioners and certified nurse midwives and allows nurse practitioners to serve as primary care providers. This mandate is estimated to increase premium by 0.16%.

- ♦ ***Coverage of Contraceptives*** (Enacted 1999)

This mandate requires health plans that cover prescription drugs to cover contraceptives. Our report estimated an increase of premium of 0.8%.

- ♦ ***Registered Nurse First Assistants*** (Enacted 1999)

This mandate requires health plans that cover surgical first assistants to cover registered nurse first assistants if an assisting physician would be covered. No material increase in premium is expected.

- ♦ ***Access to Clinical Trials*** (Enacted 2000)

This mandate requires that coverage be provided for an eligible enrollee to participate in approved clinical trials. Our report estimated a cost of 0.19% of premium.

- ♦ ***Access to Prescription Drugs*** (Enacted 2000)

This mandate only affects plans with closed formularies. Our report concluded that enrollment in such plans is minimal in Maine and therefore the mandate will have no material impact on premiums.

- ♦ ***Hospice Care*** (Enacted 2001)

No cost estimate was made for this mandate because the Legislature waived the requirement for a study. Because carriers generally covered hospice care prior to the mandate, we assume no additional cost.

- ♦ ***Access to Eye Care*** (Enacted 2001)

This mandate affects plans that use participating eye care professionals. Our report estimated a cost of 0.04% of premium.

- ♦ ***Dental Anesthesia*** (Enacted 2001)

This mandate requires coverage for general anesthesia and associated facility charges for dental procedures in a hospital for certain enrollees for whom general anesthesia is medically necessary. Our report estimated a cost of 0.05% of premium.

- ♦ ***Prosthetics*** (Enacted 2003)

This mandate requires coverage for prosthetic devices to replace an arm or leg. Our report estimated a cost of 0.03% of premium for groups over 20, and a cost of 0.08% of premium for small employer groups and individuals.

- ♦ ***LCPCs*** (Enacted 2003)

This mandate requires coverage of licensed clinical professional counselors. Our report on mental health parity indicated no measurable cost impact for coverage of LCPCs.

- ♦ ***Licensed Pastoral Counselors and Marriage & Family Therapists*** (Enacted 2005)

This mandate requires coverage of licensed pastoral counselors and marriage & family therapists. Our report indicated no measurable cost impact for this coverage.

- ♦ ***Hearing Aids*** (Enacted 2007)

This mandate requires coverage for \$1,400 for each ear every 36 months for children age 18 and under. The mandate was phased-in between 2008 and 2010, and our report estimated a cost of 0.1% of premium.

- ♦ ***Infant Formulas*** (Enacted 2008)

This mandate requires coverage for amino acid-based elemental infant formulas for children two years of age and under, regardless of delivery method. This mandate is effective January 2009, and our report estimated a cost of 0.1% of premium.

- ♦ ***Colorectal Cancer Screening*** (Enacted 2008)

This mandate requires coverage for colorectal cancer screening for persons fifty years of age or older, or less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of a national cancer society. This mandate is effective January 2009. No carriers stated they denied coverage prior to this mandate; therefore, our report estimated no impact on premium.

- ♦ ***Independent Dental Hygienist*** (Enacted 2009)

This mandate requires individual dental insurance or health insurance that includes coverage for dental services to provide coverage for dental services performed by an independent practice dental hygienist. This mandate applies only to policies with dental coverage; therefore, there is no estimated impact on medical plan premiums.

- ♦ ***Autism Spectrum Disorders*** (Enacted 2010)

This mandate requires all contracts to provide coverage for the diagnosis and treatment of autism spectrum disorders for individuals five years of age or under. Coverage may be limited for applied behavior analysis to \$36,000 per year. This mandate is effective January 2011, and our report estimated a cost of 0.7% of premium once the mandate is fully implemented if it included those under age 21. Because the mandate only applies to those up to age five, the estimate was further reduced to 0.3% of premium.

- ♦ ***Children's Early Intervention Services*** (Enacted 2010)

This mandate requires all contracts to provide coverage for children's early intervention services from birth to 36 months for a child identified with a developmental disability or delay. Benefits may be limited to \$3,200 per year. This mandate is effective January 2011, and our report estimated a cost of 0.05% of premium.

COST OF EXISTING MANDATED HEALTH INSURANCE BENEFITS

Year Enacted	Benefit	Type of Contract Affected	Est. Maximum Cost as % of Premium	
			Non-HMO	HMO
1975	Must include benefits for dentists' services to the extent that the same services would be covered if performed by a physician.	All Contracts except HMOs	0.10%	--
1983	Benefits must be included for treatment of alcoholism and drug dependency .	Groups of more than 20	0.66%	0.66%
1975 1983 1995 2003	Benefits must be included for Mental Health Services , including psychologists and social workers.	Groups of more than 20	3.42%	3.42%
		Groups of 20 or fewer	--	1.71%
1986 1994 1995 1997	Benefits must be included for the services of chiropractors to the extent that the same services would be covered by a physician. Benefits must be included for therapeutic, adjustive and manipulative services. HMOs must allow limited self referred for chiropractic benefits.	Group	0.67%	1.35%
		Individual	0.67%	1.35%
1990 1997	Benefits must be made available for screening mammography .	Group	0.67%	0.67%
		Individual	0.67%	0.67%
1995	Must provide coverage for reconstruction of both breasts to produce symmetrical appearance according to patient and physician wishes.	All Contracts	0.02%	0.02%
1995	Must provide coverage for metabolic formula and up to \$3,000 per year for prescribed modified low-protein food products.	All Contracts	0.01%	0.01%
1996	If policies provide maternity benefits, the maternity (length of stay) and newborn care benefits must be provided in accordance with "Guidelines for Prenatal Care."	All Contracts	0	0
1996	Benefits must be provided for medically necessary equipment and supplies used to treat diabetes and approved self-management and education training.	All Contracts	0.20%	0.20%
1996	Benefits must be provided for screening Pap tests .	Group, HMOs	0.01%	0
1996	Benefits must be provided for annual gynecological exam without prior approval of primary care physician.	Group managed care	--	0.10%
1997	Benefits provided for breast cancer treatment for a medically appropriate period of time determined by the physician in consultation with the patient.	All Contracts	0.07%	0.07%
1998	Coverage required for off-label use of prescription drugs for treatment of cancer, HIV, or AIDS.	All Contracts	0.30%	0.30%
1998	Coverage required for prostate cancer screening .	All Contracts	0.07%	0

1999	Coverage of nurse practitioners and nurse midwives and allows nurse practitioners to serve as primary care providers.	All Managed Care Contracts	--	0.16%
1999	Prescription drug must include contraceptives .	All Contracts	0.80%	0.80%
1999	Coverage for registered nurse first assistants .	All Contracts	0	0
2000	Access to clinical trials .	All Contracts	0.19%	0.19%
2000	Access to prescription drugs .	All Managed Care Contracts	0	0
2001	Coverage of hospice care services for terminally ill.	All Contracts	0	0
2001	Access to eye care .	Plans with participating eye care professionals	0	0.04%
2001	Coverage of anesthesia and facility charges for certain dental procedures.	All Contracts	0.05%	0.05%
2003	Coverage for prosthetic devices to replace an arm or leg	Groups >20	0.03%	0.03%
		All other	0.08%	0.08%
2003	Coverage of licensed clinical professional counselors	All Contracts	0	0
2005	Coverage of licensed pastoral counselors and marriage & family therapists	All Contracts	0	0
2007	Coverage of hearing aids for children	All Contracts	0.1%	0.1%
2008	Coverage for amino acid-based elemental infant formulas	All Contracts	0.1%	0.1%
2008	Coverage for colorectal cancer screening	All Contracts	0	0
2009	Coverage for independent dental hygienist	All Contracts	0	0
2010	Coverage for autism spectrum	All Contracts	0.3%	0.3%
2010	Coverage for children's early intervention services	All Contracts	0.05%	0.05%
	Total cost for groups larger than 20:		7.82%	8.62%
	Total cost for groups of 20 or fewer:		3.79%	6.30%
	Total cost for individual contracts:		3.78%	4.49%